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"CREATIVE FEDERALISM," "PARTNERSHIP IN HEALTH": SLOGANS OR SOLUTIONS?

THE 1969 ANNUAL HEALTH CONFERENCE
THE NEW YORK ACADEMY OF MEDICINE
COMMITTEE ON SPECIAL STUDIES

Foreword

THE *Annual Health Conference of The New York Academy of Medicine* is intended to serve as a national forum for the discussion of timely and important problems facing health care in this country. Divergent views are sought as a means of providing perspective on these issues. Through the sponsorship of such frank exchange of opinion and presentation of fact the Academy hopes that serious problems may be recognized and then resolved earlier and more rationally than might otherwise be the case.

No greater need for clarification of issues exists than in the matter under discussion. As Albert W. Snoke pointed out so well in his announcement of the conference, the expanding role of the federal government in financing and planning health services that has resulted from the massive outpouring of legislation from the 89th and 90th Congress has inaugurated a new era of contest. As the legislation moved through Congress and passed through the process of administrative regulation

and of state, local, and voluntary implementation, the product was showing signs of wear. What were hailed as great breakthroughs were now being viewed, perhaps, by the same persons as programs in serious conflict, inadequately staffed and funded. Some of those previously most skeptical or hostile to the legislation either said "I told you so," or were cheerfully complacent about the accommodations that had to be made as part of the price for the passage of the legislation.

To ensure an intelligent response to the demands of the new situation, the conference sought to look below the distinctive phrases used to describe the new era. In having each of the speakers explore the meanings of "creative federalism" from a specific point of view it was hoped that this would help reveal some of the vulnerabilities of a competing interest or opinion, if not his own.

A good deal of the complexity of the topic stems from the many sources of policy in health. Public policy in health is shaped by the changing technical capabilities of the health professions and institutions; the private health market and organizational structure including private regulatory arrangements; the group-interest structure which includes professional interests; lay interests; partisan political movements; and the governmental structure that includes complex intergovernmental relations and the functional distribution of powers among executive, legislative, and judicial branches.

Health programs share many of the characteristics of other social services in which government plays a role but also have unique characteristics. Most important of these is the explosive expansion of professionalism, in absolute number of persons and diversity of views, in interests and perspectives. If we add the fragmented professional politics in health to the complex of intergovermental relations, it is no wonder that inconsistencies in policies become magnified into major areas of conflict, and that disorderly movement forward is followed by periods of retrenchment. The slogan of "creative federalism" devised by President Lyndon B. Johnson in Ann Arbor, Mich., in 1964, sought, as Professor Robert C. Wood pointed out, to enlist a deliberate pooling of resources, agencies, and supporting groups at all levels of American government in cooperative association, with the particular mixture of rules, operating procedures, and review authorities adapted to the problem involved.[1] However, as Professor Wood points out, formulation of the concept does not solve all the problems. For each group seeks to

maximize its access to the source of power and funds often at the expense, or over the objection of, existing agencies.

The cooperative effort of various levels of government, public, and private sectors as well as their conflict predates the era of creative federalism of 1964. In a classic formulation Morton Grodzins[2] uses the image of a marble cake to describe the traditional operation of our American system, which delegates certain powers to the national government and reserves other powers to the states. The marble-cake image of federalism implies a mixing of functions at all levels, and cooperation and sharing as well as conflict. The opposing image views federalism as a layer cake in which functional separatism of activities is stressed. In our history, as in others, rhetoric and reality have not always been consistent. The role of the Public Health Service officer serving on loan in the state or local health department is only one of hundreds of examples of creative federalism that antedates 1964. What is most fascinating about federalism in health has been the shifting alliances: federal-state; federal-local; federal-private, and so on. For the most part the durable alliance in health has been federal-state but the development of such federally supported programs as health research and Medicare have been based on federal-private arrangements. On the local level the close sharing of resources by public and private health agencies has been one of the most striking characteristics of the system. But, as Grodzins' critics pointed out, in the midst of this pattern of shifting partnerships, axes, alliances, and situations of confused responsibility, a mild administrative and financial chaos emerges. How to achieve "more ascertainable responsibility for policy, administrative performance, and financing" is a goal still to be attained.[3]

A major source that seeks greater coherence in the interaction among national, state, and local governments and private health sectors is the specialist systems represented by professional groups that are linked throughout the governmental and private health structure. The administrative styles of intergovermental relations have always relied on bargaining and on an exchange of grants and skills for state, local, and private compliance with procedural and other requirements. As described earlier, the technical expansion of skills in health and increasing problems that are being faced have caused a further fragmentation of professional consensus to take place within the governmental sector. As Dr. William H. Stewart points out, "There are tremendous new responsi-

bilities in Medicare, Medicaid, Regional Medical Programs, air-pollution control, as well as old efforts in biomedical research, and support of state and local public health efforts." As Dr. Stewart notes, specialists in health on the federal level have at least seven functional areas of challenge: "1) the conduct and support of health research; 2) the training of health manpower; 3) the improvement of health facilities; 4) the provision of hospital and medical service; 5) the prevention and control of disease and disability; 6) the safeguarding of the quality of the environment; and 7) protection of the consumer."[4]

The specialists in each area represent different perspectives, interests, and career motivations. Serious issues of priorities, organization, and values also exist within each discipline. The emergence of a cadre of elite professionals that could provide over-all leadership to the system is problematical, for the egalitarian strains in American society and the growing fragmentation among specialists caused by changes in health techniques makes this almost impossible.

A sizable share of our troubles in health programs is attributed by many to a lack of national policy in health and, where such policy exists, to a lack of consensus of the best means to achieve such policy. The debate on "health care as a right" illustrates this. Even where there is agreement on the over-all goal, the implication for specific policies is unclear. Unfortunately institutional arrangements to increase the rationality of decision making are in a stage of early development. Regional Medical Programs and Comprehensive Health Planning are just at their starting point and may undergo drastic change before they or companion programs have any impact.

In addition to the emergence of new institutional arrangements and initiatives in policy the need to encourage the emergence of groups and alliances—especially those representing disadvantaged persons—that represent broader perspectives than those of groups advocating narrow interests—whose voices are now the loudest—was perceived by many participants in this conference. Where the benefits derived from governmental programs are small the administrative style based entirely on ad hoc bargaining and negotiation may be appropriate. But in an era of massive federal programs and new problems, the old style and the old ideology comprised of fear of an all powerful bureaucracy are plainly inadequate. "Creative federalism" points to new ways of doing things and of looking at the relations existing within the public and

private sectors. The contributors to this health conference have sought to bring the reality closer to the ideal.

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3. Perkins, J. A. and Redford, E. S. Ibid, p. 282.
4. Statement of Dr. William H. Stewart, Surgeon General, U.S. Public Health Service, in hearings before the Subcommittee on Departments of Labor and Health, Education, and Welfare Appropriations of the Committee on Appropriations held March 14, 1969.